LIFE
SPECIALTY SOLUTIONS

RECLAST

PATIENT INFORMATION

PATIENT NAME: ____________________ PHONE #: ____________________

ADDRESS: ____________________ CITY, STATE, ZIP: ____________________

DATE OF BIRTH: ____________________ EMAIL: ____________________

ALLERGIES: ☐ SEE LIST ☐ NKDA WEIGHT: ☐ LB OR ☐ KG

REQUIRED DOCUMENTATION

1. Insurance Card 2. History & Physical 3. Patient Demographics 4. Most Recent Labs 5. Medication List
6. DEXA Scan 7. Current Calcium Level (within 6 months) 7. CrCl clearance

PRIMARY DIAGNOSIS

☐ M80.00xA Age-related osteoporosis with current pathological fracture, initial encounter

☐ M80.00xS Age-related osteoporosis with current pathological fracture, sequela

☐ M81.0 Age-related osteoporosis without current pathological fracture

☐ Other ____________________

LABS ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: ____________________

PRE-MEDICATIONS

☑ Per infusion clinic protocol: There are no recommended standard pre-meds

☐ Provider Prescribed: ____________________

PRIMARY MEDICATION ORDER

Reclast IV

☐ Reclast (Zoledronic Acid) 5mg IV x 1 dose

FIRST DOSE?: ☐ Yes ☐ No

☐ Other ____________________

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Parkway Pain Care & Rehabilitation PC - Life Specialty Solutions (See lifespecialtysolutions.com for detailed policy)

☐ Other: (Please send other reaction orders if checking this box)

PRESCRIBER INFORMATION

PROVIDER NAME: ____________________ PHONE: ____________________

OFFICE CONTACT: ____________________ FAX: ____________________

ADDRESS: ____________________ EMAIL: ____________________

CITY, STATE, ZIP: ____________________ NPI AND LICENSE: ____________________

✕ ____________________ ____________________

PROVIDER SIGNATURE DATE